Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

Respondent Name
TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-13-0746-01

MFDR Date Received
NOVEMBER 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Buckner Village Pharmacy Globe Pharmacy"

Amount in Dispute: $1,707.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Carrier denied reimbursement of those expenses on the basis that they were not reasonable and necessary medical treatment to cure or relieve the effects of the compensable injury."

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Ste. A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2009 through September 10, 2010	Out of Pocket Expenses for Prescription Medications UNTIMLEY SUBMITTED	$1,420.00	$0.00
May 10, 2012 through July 9, 2012	Out of Pocket Expenses for Prescription Medications TIMELY SUBMITTED	$287.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §134.504 sets out the guidelines for pharmaceutical expenses incurred by the injured employee.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits was not submitted by either party.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in a timely manner?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. In accordance with 28 Texas Administrative Code §133.307, a requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. According to §133.307(c)(1)(A), a request for MFDR shall be filed no later than one year after the date(s) of service in dispute. Review of requests of documentation provided finds that dates of service in dispute are March 16, 2009 through July 9, 2012. Based on the date that this medical fee dispute was received in MFDR (January 10, 2013), the division concludes that:
    - dates of service March 16, 2009 through September 10, 2010 were not submitted timely to MFDR; therefore the requestor has waived its right to medical fee dispute resolution for these dates; and
    - dates of service May 10, 2012 through July 9, 2012 were submitted timely; therefore these dates shall be reviewed in accordance with the applicable Texas Labor Code provisions and applicable rules.
2. 28 Texas Administrative Code §133.305(a)(5) (effective July 1, 2012) defines a medical fee dispute as "a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury." 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021 According to 28 Texas Administrative Code §133.307(f)(3)(B) (effective May 31, 2012), the request contains an unresolved adverse determination of medical necessity. Review of the submitted documentation, for dates of service May 10, 2012 through July 9, 2012, finds that there are unresolved issues of medical necessity for the same services for which there is a medical fee dispute. No documentation was submitted to support that the issue of medical necessity has been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.